Patient Safety Innovation Award - 2019 Nomination Form

For questions about submitting a nomination for the award, contact Casey Hutchens chutchens@IHAconnect.org.

Overview

The Indiana Patient Safety Center (IPSC) has established the annual Patient Safety Awards to recognize individuals, groups and organizations who have helped bring Indiana closer to the goal of zero patient harms. These awards will honor commitment and enthusiasm for improving patient safety in hospitals and communities across the state.

The Patient Safety Innovation Award recognizes an individual, group or program that has developed innovative ways to improve, encourage or enhance patient safety within their hospital, health system, regional patient safety coalition or professional organization. This could mean developing a new program, process or campaign or leveraging an existing process or tool in a new way. Winners will demonstrate creativity and forward thinking.

Submit your nomination by filling out the following form and submitting a brief narrative. Supporting documents may be attached to enhance your nomination.

The nomination period is open from Feb. 25 to April 8. Nominations will be carefully considered by a committee of health care professionals and patient safety advocates, with winners announced at the Patient Safety Summit June 4.

2018 Winner: The Comprehensive Transitions of Care (TOC) Pharmacy Program at Franciscan Health Hammond Hospital

The Comprehensive Transitions of Care (TOC) Pharmacy Program at Franciscan Health Hammond Hospital received the 2018 Patient Safety Innovation Award for their outstanding work improving continuity of care medication safety by targeting high-risk patients to receive a TOC pharmacist evaluation of patient's medication therapy. Through this unique approach to patient care, the team at Franciscan Health Hammond Hospital removed patient care silos by bridging the gaps in care in all aspects of a patient's healthcare experience. The Comprehensive Transitions of Care (TOC) Pharmacy Program was created to bridge gaps in transition of care from the hospital to home and, ultimately, decrease hospital readmissions of high-risk patients.

2019 Nomination Form

NOMINATOR INFORMATION

Name *

Jessa Henney

Job Title *

Network Medication Safety Director

Hospital/Organization *

Community Health Network

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NOMINEE INFORMATION

I am nominating a(n) *

- ○ Individual
- ◉ Group/Team/Coalition
- ○ Organization

If group, team, coalition, or organization, please include name

TempTrak Barrier Analysis Team

Contact Name *

Ginger Breeck

Job Title *

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Hospital/Organization *

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NOMINATION REASONING

Please write a brief narrative below that describes why this nominee deserves to be recognized. Please incorporate the answers to the following questions in your narrative based on the award you indicated above.

Write response here *

After becoming aware of a potential safety event, Community Health Network (CHNw) recognized the need to investigate across the network the integrity of processes surrounding temperature monitoring. The discovery process contained several components including: over 25 interviews with content matter experts and staff in a variety of roles, review of records, vendor consultations, and a robust literature search. While gathering background information, the scope expanded to include other products and temperature controls units (TCUs) outside of refrigerated medications. These products and TCUs included: breast milk, patient nutrition, bone/tissue, point of care supplies, warmers (i.e. blanket and mannitol), freezers, and morgue storage. Through the course of the analysis, it was recognized a multitude of process variations existed with temperature monitoring. This included, but was not limited to: quality of TCUs and temperature monitoring equipment, standardization of temperature and alert profiles, interpreting software reports, and importance of daily monitoring. The barrier analysis stakeholders took ownership of addressing the identified needs by creating five workgroups all responsible to create a mitigation strategy. Throughout the course of the year, over 65 CHNw caregivers shared their expertise within these five workgroups to create and deploy a new temperature monitoring process across an entire network.

PATIENT SAFETY INNOVATION AWARD

Please complete all questions below.

What patient safety initiative has this individual/group/organization created or led? *

Creation of a multi-product, comprehensive temperature monitoring process with the ability to be utilized across all areas within a health care system.

What need did this initiative fill, or what problem did it solve? *

Addressed the lack of process consistency, which lead to variations in practice, equipment quality, excursion responses, understanding of responsibilities, and accountability.

What made this initiative innovative or unique from existing efforts? *

- Over 65 Subject Matter Experts participated within the course of a year
- Scope included both acute and ambulatory settings
- Addressed over 15 barriers identified from the analysis through 5 unique workgroups
- Stakeholders included both leadership and direct patient caregivers
- Executive sponsors from network C suite level (Network Chief Financial Officer and Network Chief Operations Officer)
- Shared vision was effectively communicated allowing significant financial and human resources dedicated to improving this process
- Inclusion of front line staff as workgroup facilitators providing them an opportunity for leadership experience
- Stakeholders from various clinical and non-clinical departments
- To prevent duplicative work amongst the 5 workgroups, the two analysts were assigned to serve as a liaison to the various groups, periodic workgroup facilitator meetings were held, and checklists were created to provide defined group outcomes.
- All decisions were documented and based upon the following: regulatory readiness concepts and best practices noted in literature.

What results did this initiative produce? *

- Temperature profile reduction/standardization (previously had over 100 different profiles and were able to create 18 standardized profiles)
- Creation of a centralized resource that is easily accessible to all employees via the organization's intranet
- Standardization of the following processes: equipment (TCU and temperature monitoring) acquisition, preventive maintenance, centralized contact for process questions and concerns, temperature excursion response plan, equipment nomenclature, alarm response, departmental plan, event reporting and documentation, alarm escalations, and preparation set up checklist
- Defined responsibilities within each step of the process (examples: generating reports, daily monitoring, IT/facilities support, etc.)
- Created one integrated network policy
- Developed a standing multi-disciplinary steering committee to address concerns and issues in real time
- Established a communication plan to all departments through an assigned designee to ensure optimal communication between the steering committee and departments
- Dedicated funding to ensure all products included within the scope of this analysis will be stored within an approved vendor supplying medical/pharmaceutical grade units
- Reduction of temperature excursions
- Reduction of alerts (example data: One hospital reviewing pharmacy products stored went from 4.13 alerts/day to 0.84 alerts/day)
- Decrease alarm response time (example data: one hospital reviewing pharmacy products stored went from an average response time of 2.75 hours to 1 hour)
- Reduction of time of temperature sensors/units being out of range (example data: one hospital reviewing pharmacy products stored went from an average of all units being out of range 2.3% of the time per month to 0.25% of the time per month; Percentage of units that were 100% in range for the month went from 48.6% to 64.6%)

Has this innovative initiative been recognized by other individuals or groups, or has it been replicated by others since its implementation? *

This was shared with various workgroups within the Indianapolis Coalition for Patient Safety (ICPS). Other city hospitals acknowledge the potential for patient harm as a result of gaps within their current temperature monitoring processes.

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